
Methods and Standards for
Establishing Payment Rates: Other Types of Care

Advanced Nurse Practitioners

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. Except as otherwise noted in the plan, state developed fees schedule rates are the same for both governmental and private providers. The fee schedule and its effective date are published at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers. The fee schedule is published at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitative services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavioral Rehabilitative Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards. Rates and rate methodology are found in Residential Behavioral Health Service handbook 2013 at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx>.

Certified Nurse Anesthetist

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factors and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year, and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

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Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an RVU. State developed fee schedule rates are the same for both public and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

EPSDT Screening Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology for physicians or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Freestanding Birthing Center Services

Facility rates for freestanding birthing centers are based on 75 percent of the weighted average of the Medicaid hospital inpatient rates paid to the general acute care hospitals in Anchorage, Fairbanks, Juneau, Palmer, and Soldotna with a one day length of stay designated by a primary diagnosis code of 080 as described in the *International Classification of Diseases – 10th Revision, Clinical Modification* (ICD-10-CM, adopted by reference in 7 AAC 160.900; this amount is calculated each state fiscal year using the units of services from the most recent 12 month period starting at the beginning of the state fiscal year's fourth quarter and for which timely filing has already passed and the Medicaid hospital inpatient rates for each facility that are in effect at the start of the fourth quarter of the state fiscal year preceding the July 1 effective date. For SFY20, July 1, 2019 through June 30, 2020, the payment rate will be 95% of the rate that would have been effective July 1, 2019.

Licensed Behavior Analysts

The state Medicaid program reimburses for behavior analysis services through the supervising health care provider - who is a licensed behavior analyst operating within their scope of practice.

All covered services are paid at the lesser of the provider's billed charges, or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of behavior analysis services. Tribal behavioral health clinic encounter rates do not apply to services in this section.

The fee schedule and its effective date are published at
<http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx> .

In SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the SFY19 rates.

OTHER LICENSED PRACTITIONERS

Licensed Psychologists

The state Medicaid program reimburses for services provided by a licensed psychologist operating within their scope of practice.

All covered services are paid at the lesser of the provider's billed charges or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of services.

The fee schedule and its effective date are published at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx> .

Licensed Clinical Social Workers

The state Medicaid program reimburses for services provided by a licensed clinical social worker operating within their scope of practice.

All covered services are paid at the lesser of the provider's billed charges or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of services.

The fee schedule and its effective date are published at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx> .

Licensed Marriage and Family Therapists

The state Medicaid program reimburses for services provided by a licensed marriage and family therapist operating within their scope of practice.

All covered services are paid at the lesser of the provider's billed charges or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of services.

The fee schedule and its effective date are published at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx> .

EPSDT Continuing Care Provider Services

Continuing care providers, who have entered into an agreement with the Division of Medical Assistance in accordance with Section 3.1 (a)(9) of this Plan, will be reimbursed an amount equal to the costs associated with implementing the provisions of such an agreement.

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Dental Services for Recipients Age 21 or Older:

Payment is made at the lesser of billed charges, the Medicare Resource Based Relative Value Scale Methodology used for physicians in those instances where Medicare sets an RVU for the billed dental service, the provider's lowest charge, or the statewide fee schedule up to an annual limit of \$1150 per Medicaid recipient age 21 or older.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dental services. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>. This fee schedule includes dental procedures whose payments are limited by the physician payment amount for dental procedures.

Dentures:

For recipients age 21 and older, dentures and the authorized services to prepare for them, are paid up to an annual limit of \$1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dentures. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for dental services published at

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Family Planning Services and Supplies

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures without an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule.

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Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease on the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments. For state fiscal year 2016, 2017, and 2018, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases on the scope of service furnished by the Center during that fiscal year. For state fiscal year 2016, 2017, and 2018, after the initial year for a center, the center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase on the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

Alternative Prospective Payment System

Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Health Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review, Skilled Nursing Facility Total Market Basket*, inflated to 2002.

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The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review, Skilled Nursing Facility Total Market Basket*, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review, Skilled Nursing Facility Total Market Basket*, then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates. For state fiscal year 2018, rebasing using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. For the state fiscal years 2016, 2017, and 2018, if the center's base year is not changing, then the center's payment rate is not increased using the first quarter publication of Global Insight's *Health Care Cost Review, Skilled Nursing Facility Total Market Basket*, but is adjusted for any increase or decrease in the scope of services.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation.

If the rate established using the alternative prospective payment, methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center may apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how Medicaid patients will lose access available to the general public in the same geographic location without this relief, and any other information requested by the deputy commissioner to evaluate the request.

The alternative payment methodology agreement between the State and the federally Qualified Health Center will result in payment to the FQHC of an amount that is equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a statewide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year. For state fiscal year 2016, 2017, and 2018, if it is a center's subsequent year, the center will be paid the rate it was entitled to the previous fiscal year with no percentage increase in the Skilled Nursing Facility Total market Basket, but adjusted for increases or decreases in the scope of services furnished by the center during that center's fiscal year.

Home Health Services

Payment is made at 80 percent of billed charges.

Hospice Care Services

Payment is set and adjusted according to the yearly releases from the Centers for Medicare & Medicaid Services (CMS). Alaska's Medicaid program adjusts the rates by the start of the CY (January 1) immediately after the release of the updated rates by CMS, and these rates are retroactive to the effective date of the CMS material released (usually, October 1 of each year).

Laboratory Services

Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. For SFY20, July 1, 2019 through June 30, 2020, the payment rates for laboratory services not provided by independent laboratories will be 95% of what the payment would have been July 1, 2019. The state Medicaid program recognizes the Medicare fee schedule in place as of June 1 for the annual update of these rates that occurs at the beginning of the next SFY (on July 1). Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of the billed charges or the Resource Based Relative Value Scale methodology used for physicians.

Durable Medical Equipment, Medical Supplies, and Prosthetic and Orthotic Devices

Reimbursement for durable medical equipment and supplies dispensed by enrolled durable medical equipment (DME) and prosthetic and orthotic (P&O) providers to recipients physically located in the state is made at the lesser of the amount billed, the Medicare rate current at the time of dispensing, or the state maximum allowable posted on the fee schedule.

Reimbursement for dispensed medical supplies and prosthetic and orthotic devices identified as billable only by an enrolled certified P&O provider occurs at the lesser of the amount billed, the Medicare rate current at the time of dispensing multiplied by 1.2, or the state maximum allowable posted on the fee schedule.

Effective June 2, 2019 for prosthetic and orthotic supplies, and July 2, 2019 for durable medical equipment, that do not have an established Medicare rate or established state maximum allowable rate at the time of dispensing, the agency sets rates based on a methodology set in regulation and publishes the rate on the agency's fee schedule site (<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>).

For a covered, non-priced, non-miscellaneous Healthcare Common Procedure Coding System (HCPCS) code, the rate is based on the submitted unaltered final purchase invoice price plus 35 percent for claims submitted on or after June 2, 2019, and before the date the rate is established, until CMS or the department sets a rate:

- (1) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first 10 claims is less than \$5,000, the final rate will be set at
 - (A) the median submitted unaltered final purchase invoice price of the first 10 claims plus 35 percent if the first 10 claims were paid to at least two different enrolled providers; or
 - (B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 35 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

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- (2) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first ten claims is \$5,000 or more, the final rate will be set at
- (A) the median submitted unaltered final purchase invoice price plus 30 percent if the first ten claims were paid to at least two different enrolled providers; or
 - (B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 30 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

Reimbursement rates for covered items submitted using an HCPCS code, for which CMS or the department has not issued a rate, will be reimbursed at the unaltered final purchase invoice price plus 20 percent.

Used or refurbished durable medical equipment will be reimbursed at no more than 75 percent of the allowed rate for the specific HCPCS code.

Rental rates are set at 10 percent of the total allowed price of the item.

Reimbursement rates for items and services provided to recipients when the recipient is physically located outside of this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in the state where the item or service was provided.

Reimbursement for unusual or custom equipment may be authorized on a case-by-case basis and may not exceed the authorized amount.

Due to the unique remote geography of Alaska, payment for the reasonable and necessary direct costs of delivery or shipping using the most cost-effective method may be authorized if:

- the recipient resides outside the municipality where the enrolled provider is physically located, and the item or service is unavailable from an enrolled provider in the municipality where the recipient resides;
- the item is durable medical equipment or replacement parts that are specialized or unique to a recipient's equipment, is shipping from the manufacturer, and the cost of the item exceeds \$250; or
- the item is a home infusion therapy product, and the cost of shipping exceeds 40 percent of the sum of the per diem rate for the number of days of therapy represented in the shipment.

For certain durable medical equipment (DME) that are also covered by Medicare, the state will reimburse at no more than Medicare rates current at the time of dispensing. As such, the aggregate amount expended by the state Medicaid program for DME should compare as equal to or less than the aggregate amount which would be paid for such items on a fee-for-service basis under Medicare Part B, including as applicable, under section 1847 of the Act. If payments for DME items subject to statute exceed the FFP limit outlined in section 1903(i)(27) of the Act, the overpayment shall be returned to CMS.

For SFY20, July 1, 2019 through June 30, 2020, products and services with rates set under this section will be paid at 95% of these rates when rendered incident to a professional service by exempt provider types not listed in this section but outlined in 42 CFR 424.57 (physicians, authorized non-physician practitioners, PT, OT).

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Mental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a physician) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Behavioral Health under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally ill persons seeking admission to or residing in long-term care facilities. The state assures that the requirements of 42 CFR 447.321 regarding upper limits of payment will be met. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of mental health clinic services. The agency's fee schedule and effective date is published at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx>. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95 percent of the rates that were effective 1/1/2019.

Mental Health Rehabilitation Services

Mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Except as otherwise noted in the plan state developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule and effective date is published at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx>. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95 percent of the rates that were effective 1/1/2019.

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85% of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of nurse-midwife services. The fee schedule and effective date is available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

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Nutrition Services

Payment to a registered dietitian is limited to the lesser of the amount billed the general public or a maximum of \$50 for an initial assessment, counseling, or evaluation; and \$35 for each subsequent visit.

Outpatient Hospital Services

Rate setting principles and methods for Outpatient Hospital Services are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43. The Department of Health and Social Services uses the following data sources for setting rates of payment:

- When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 12 months before the beginning of the year that is rebased (base year).
- Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.
- Year-end reports that contain historical financial and statistical information submitted by facilities for past rate setting years.
- Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Medical Assistance.

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those that directly relate to Title XIX program recipients. Costs would include those necessary to conform to state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible allowable and unallowable cost adjustments from financial statement classifications to Medicaid classifications that may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

- 1) physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.
- 2) medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.
- 3) costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.
- 4) management fees or home office costs which are not reasonably attributable to the management of the facility are not allowable. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.
- 5) return on investment is not an allowable cost for any facility.

(Outpatient Hospital Services, continued)

- 6) advertising cost is allowable only to the extent that the advertising is directly related to patient care.

The reasonable cost of the following types of advertising and marketing is allowable:

- announcing the opening of or change of name of a facility.
- recruiting for personnel.
- advertising for the procurement or sale of items.
- obtaining bids for construction or renovation.
- advertising for a bond issue.
- informational listing of the provider in a telephone directory.
- listing a facility's hours of operation.
- advertising specifically required as a part of a facility's accreditation process.

- 7) advocacy and lobbying expenses, along with any costs related to these activities, are not allowable.

- 8) costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue and the judgment doesn't include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

Allowable patient-related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments, and discounts taken by payers. When regulatory changes in allowable costs become effective after the last adjustment for inflation, base year costs and rate calculations may be adjusted and new rates applied to claims with dates of service after the effective date for such regulatory changes.

Prospective payment rates for outpatient hospital services are a percentage of charges except outpatient clinical laboratory services and provider-based clinic services. Except as stated in this Subsection, the prospective payment rate for outpatient clinical laboratory services will be a per-procedure rate based on reasonable costs as determined by the Medicare fee schedule.

The prospective percentage of charges payment rate for acute hospital outpatient services is determined by applying the outpatient cost to charge ratio for each outpatient cost center from the Medicare Cost Report to the cost center's Medicaid outpatient charges. Laboratory and clinic cost centers are not included in the calculation. The sum of the Medicaid outpatient costs for all outpatient cost centers will then be divided by total Medicaid outpatient charges. The resulting cost to charge percentage, not to exceed 100 percent, will be the prospective outpatient payment rate effective for the fiscal year. Facilities choosing reimbursement under the Optional Prospective Payment Rate Methodology for Small Facilities described in Attachment 4.19A will have their outpatient clinical laboratory services reimbursed at their prospective outpatient percentage of charges payment rate for the term of their agreement. Rebasing will occur for all facilities no less than every four years. For state fiscal year 2018, rebasing of prospective payment rates using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. Facilities that currently are receiving exceptional relief and are scheduled to be rebased in state fiscal year 2018 will not be affected by the rebasing freeze in state fiscal year 2018. For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year 2017. For state fiscal

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(Outpatient Hospital Services, continued)

year 2020, July 2, 2019 through June 30 2020, the payment rate for hospitals that are not licensed as Critical Access Hospitals will be paid at 95% of the rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals through the State of Alaska, Division of Health Care Services, Health Facilities Licensing Certification List, updated February 28, 2019, will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions under this subsection.

Facilities may choose to be reimbursed under an Optional Prospective Payment Rate Methodology for Small Facilities. A small acute care hospital facility is defined as one that had 4,000 or fewer total inpatient hospital days as an acute care, specialty, or psychiatric hospital or at a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year.

A small acute care hospital may elect a new four-year rate agreement if the facility becomes a combined acute care hospital-nursing facility and meets the qualifications described in this section. The facility may choose this option within 30 days after the two facilities combine. The outpatient percentage rate is calculated as the statewide average of the outpatient payment rates in effect for all qualified acute care hospital small facilities as of the date the facilities combine.

For a new facility, the outpatient prospective payment rate percentage is established at the statewide weighted average outpatient payment percentages of acute care and specialty hospitals, in accordance with this section for the most recent 12 months of permanent rates. The outpatient percentages are the statewide weighted average using the base year's outpatient charges. To determine this weighted average, Medicaid charges for the most recent 12 months from each facility are multiplied by the facility's respective rate to get the payment. The sum of facilities' payments is then divided by the sum of their charges to calculate a weighted average outpatient payment percentage.

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Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Except as otherwise noted in the plan, payment for these services is based on state developed fee schedule rates, which are the same for both governmental and private providers of personal care services. The agency's rate for personal care services updated on 7/1/2019, are effective for services rendered on or after 07/01/19. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for personal care services published at <http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the SFY19 rates.

Personal Care Services for Community First Choice Option

Effective for services provided on or after January 1, 2018, providers of Personal Care Services for Community First Choice eligible recipients will be reimbursed at fee for service rates built on the base rate of the Personal Care Attendant adjusted to include:

- Salaries for Personal Care Supervisors and Personal Care Attendants
- Fringe Benefits for Personal Care Supervisors and Personal Care Attendants
- Training time for Personal Care Supervisors and Personal Care Attendants

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective date is published at <http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>.

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for the physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physical and occupational therapy services. The fee schedule and its effective dates is available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

Physician Assistants

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU. State developed fee schedules are the same for both public and private providers. The fee schedule and effective date is available at: <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

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Physician Services:

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Surgical reimbursement is in accordance with the Resource Based Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting the payment between the two surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Payment to physicians for in-office laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to independently enrolled hospital-based physician for certain services at the lesser of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using the base units and time units and a state determined conversion factor.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Effective July 1, 2019, physician services reimbursement will be set using the Medicare Relative Value Units, updated on a quarterly basis, and the most recently published Medicare Geographic Practice Cost Index for the state of Alaska. The state of Alaska applies a conversion factor of \$40.974 to the formula in the calculation of an RBRVS rate. The fee schedule and effective date is available at: <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

For SFY20, July 1, 2019 through June 30, 2020, the conversion factor for provider types that are not direct entry midwife, school based services, family planning clinics, or independent laboratory, or are any provider type but have a specialty codes on the rendering provider that is not general practice, family practice, gynecology, obstetrics and gynecology, pediatrics, obstetrics, adult health, nurse midwife, women's health/OB-GYN, family health, pediatric, or gerontological, will be \$37.792.

Methods and Standards for
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Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and effective date is available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Prescribed Drugs

- The Department will use the National Average Drug Acquisition Cost (NADAC), as calculated and supplied by the Centers for Medicare and Medicaid Services, as the state maximum allowable cost for both brand and generic drugs.
 - When considering the amount billed by the provider, the lowest of the following will be the amount billed: gross amount due, usual and customary pricing, and submitted ingredient cost plus the professional dispensing fee.
- (A) Drugs acquired outside of 340B or FSS, including 340B covered entities that purchase drugs outside of the 340B program and contract pharmacies under contract with a 340B covered entity described in section 1927(a)(5)(B) of the Act -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, state maximum allowable cost (SMAC) plus professional dispensing fee, or the federal upper limit (FUL) plus the professional dispensing fee.
- (B) Specialty Drugs that are not distributed by a retail community pharmacy and distributed primarily through the mail -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the FUL plus the professional dispensing fee.
- (C) Drugs not distributed by a retail community pharmacy, such as in or for a long-term care facility -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the FUL plus the professional dispensing fee.
- (D) Indian Health Service, tribal, and urban Indian facilities (pharmacies, dispensing providers) purchasing drugs through the Federal Supply Schedule (FSS) -
- Reimbursement for drugs provided by a facility purchasing drugs through the Federal Supply Schedule or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program, will not exceed the acquisition cost, as outlined in regulation for such facilities, plus the professional dispensing fee.
- (E) 340B purchased covered outpatient drugs

-
- Reimbursement for drugs for a covered entity described in U.S.C. 256b, that indicates it will use covered outpatient drugs purchased through the 340B pricing program to bill to Medicaid, will be the lower of the submitted actual acquisition cost plus professional dispensing fee, WAC +1% plus professional dispensing fee, the SMAC plus professional dispensing fee, or the FUL plus professional dispensing fee.
- (F) Drugs acquired through the 340B program and dispensed by contract pharmacies under contract with a 340B covered entity described in section 1927 (a)(5)(B) of the Act will not be reimbursed. Compounded Drugs
- 1) Reimbursement for compounded prescriptions will be the sum of the costs of each of the ingredients as established under (A) through (E) above plus the professional dispensing fee to reimburse no more than the provider's lowest charge.
 - 2) The professional dispensing fee for a compounded covered outpatient drug is the applicable fee listed in (K) of this subsection.
- (G) Physician-administered drugs
- 1) Physician administered drugs including those purchased through the 340 B program are reimbursed at the lower of the billed amount or WAC + 1% without a professional dispensing fee.
 - 2) Physician administered drugs will be reimbursed for the drug without a professional dispensing fee.
 - 3) For SFY2020 (after a 30-day notice to providers, prescribed drugs billed under provider types other than those by a Pharmacy (pharmacy administered drugs) will be paid at 95% of these rates
- (H) Clotting factor
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the federal upper limit plus the professional dispensing fee.
- (I) Drugs other than those of (A) through (H) above, and for brand names of multiple source drugs, specified by the prescriber, without a specific established limit in accordance with 42 C.F.R. 447.512, will be reimbursed the lesser of the provider's billed amount or WAC + 1%, plus the professional dispensing fee.
- (J) Investigational and Experimental Drugs
- 1) Reimbursement will not be provided for investigational drugs.
 - 2) Reimbursement will not be provided for experimental drugs.
- (K) Professional Dispensing Fee
- 1) The professional dispensing fee is based on the results of the surveys of in-state pharmacies' costs of dispensing prescriptions. For each pharmacy, the professional dispensing fee will be reimbursed no more than once every 22 days per individual medication strength, and based on the following schedule:

(a) For pharmacy located on the road system:	\$13.36
(b) For a pharmacy not located on the road system:	\$21.28
(c) For an out-of-state pharmacy:	\$10.76
(d) For a mediset pharmacy:	\$16.58
 - 2) The department will reimburse the lesser of the pharmacy's assigned professional dispensing fee based on the schedule above, or the submitted dispensing fee.
 - 3) Professional Dispensing Fee Schedule Description
 - (a) "pharmacy located on the road system" means a pharmacy in this state and is connected to

- Anchorage by road;
- (b) “pharmacy not located on the road system” means a pharmacy located in this state and is not connected to Anchorage by road;
 - (c) “out of state pharmacy” means a pharmacy that is physically located in a state other than this state;
 - (d) “mediset pharmacy” means a pharmacy dispensing 75% or more of the total annual Medicaid prescription for covered outpatient drugs in prescriber-ordered medisets or unit doses to a recipient living in a congregate living home, a recipient of home and community-based services, a recipient eligible for Medicaid under a category set out in 7 AAC 100.002(b) or (d) who is blind or disabled, a recipient who is an adult experiencing a severe emotional disturbance.

(L) Miscellaneous and Definitions

- Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and not directly reimbursed.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Private Duty Nursing for Children Under 21

Payment for private nursing is the lesser of amount billed the general public or \$80 per hour for registered nurse services and \$75 per hour for licensed practical nurse services. Hours must be justified in a physician-approved plan of care, must be less than 24 hours per day, and cannot, when added to the other Medicaid services used by the child, exceed the cost of institutional care. For SFY20, July 1, 2019 through June 30, 2020, rates will be 95% of the SFY19 rates.

Radiology Services

Payment for radiology services provided by independent radiology facilities is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. This maximum allowable payment is a single rate per procedure code. The fee schedule and effective dates are available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>. The state assures that the requirement of 42 CFR 447.325 regarding upper limits of payment will be met.

Renal Dialysis Physician Clinics

Payment for renal dialysis clinic services will be paid at a composite, per treatment payment rate for hemodialysis and a separate composite per treatment rate for peritoneal dialysis. No more than one treatment may be billed per day, and no more than three hemodialysis treatments may be billed per week without medical justification.

The rates for end-stage renal disease facilities are all-inclusive, except that the department will pay for erythrocyte-stimulating agents and parenteral iron replacement products, which are separately reimbursable under existing prescribed drug payment methodology.

The composite, per treatment payment rates for hemodialysis and peritoneal dialysis will be adjusted annually each July 1.

The composite, per treatment payment rates for hemodialysis and peritoneal dialysis will be calculated as statewide weighted averages. The following will be used to develop the statewide weighted averages:

- a. Alaska Medicaid claims information that identifies the number of hemodialysis and separately the number of peritoneal dialysis treatments delivered to Alaska Medicaid recipients during the most recent calendar year for which timely filing has passed; and
- b. The average cost per treatment included on Medicare Cost Reports submitted by end-stage renal disease clinics for the calendar year aligning with a) above.

The hemodialysis cost per treatment will be taken from the Average Cost of Treatments Value entered on the Computation of Average Costs per Treatment Basic Composite Cost worksheet for maintenance hemodialysis portion of the Medicare Cost Reports submitted by end-stage renal disease clinics. The cost of the peritoneal cost per treatment will be taken from the average cost of treatments value reported on the Computation of Average Costs per Treatment Basic Composite Cost worksheet for Home Program Continuous Ambulatory Peritoneal Dialysis (CAPD) and for Home

Program Continuous Cycling Peritoneal Dialysis (CCDP) portion of the Medicare Cost Reports submitted by end-stage renal disease clinics.

When the average cost of treatments from the Computation of Average Costs per Treatment Basic Composite Costs are reported as weekly costs on the Medicare Cost Reports submitted by end-stage renal disease clinics, the department will divide hemodialysis values by three treatments per week and peritoneal dialysis values by seven treatments per week to arrive at the average cost per daily treatment.

Respiratory Therapy Services

Payment for respiratory therapy services is made at the lesser of the amount billed the general public or the state maximum allowable. This maximum allowable payment is a single rate per procedure code. The agency's rates for respiratory therapy services were updated on July 1, 2019 and are effective for dates of service after on or after that date.

Rural Health Clinic Services

Payment for Rural Health Clinic Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Rural Health Clinic Services are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates are set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic. The clinic must supply documentation to justify scope of service adjustments.

For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

Alternative Prospective Payment System

Beginning with the Rural Health Clinic's fiscal year 2003 (FY03), qualifying clinics may agree to have their payment rates set using the alternative prospective payment system outlined below. The alternative payment methodology agreement between the State and the Rural Health Clinic (RHC) results in payment to the RHC of an amount at least equal to the Prospective Payment System (PPS) payment rate. The state annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for fiscal year 1999 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket inflated to 2002.

The clinic's allowable and reasonable costs for fiscal year 2000 will be inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the clinic to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review*, Skilled Nursing Facility Total Market Basket and then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation. Prescription drugs are subject to drug coverage limitations in 7 AAC 43.490 and are reimbursed in accordance with 7 AAC 43.591. Hospital deliveries are reimbursed in accordance with 7 AAC 43.107(b).

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the clinic may apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how

**Methods and Standards for
Establishing Payment Rates: Other Types of Care**

The alternative payment methodology agreement between the State and the Rural Health Clinic will result in payment to the Rural Health Clinic of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for Rural Health Clinics becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other clinics or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the clinic will be paid the rate it was entitled to the previous clinic fiscal year increased by the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the clinic during that clinic's fiscal year.

Description of Service Limitations

School-Based Rehabilitative Services

The division will reimburse an enrolled school district for those procedures identified in the United States Department of Health and Human Services, Centers for Medicare and Medicaid's (CMS) Healthcare Common Procedure Coding System (HCPCS) 2003 that are provided as a rehabilitative service. Payment is made at 85% of the rate identified in the State's fee schedule for all providers of physical therapy, occupational therapy, speech-language therapy, and hearing services, whether school-based or community-based. The maximum allowable rates for all services are calculated using the Resource Based Relative Value Scale (RBRVS) methodology described in 42 CFR 414. The relative value units used are the most current version published in the Federal Register.

Speech, Hearing, and Language Services:

The department will pay for speech pathology/audiology services if they are identified in the *CPT Fee Schedule for Speech Pathologist table and HCPC Fee Schedule for Speech Pathologists table*.

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment for hearing services provided by an audiologist is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable. The fee schedule and effective date is available at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Substance Abuse Rehabilitation Services:

The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

1. assessment and diagnosis services;
2. outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
3. intensive outpatient services;
4. intermediate services; and
5. related medical services, including medical evaluation for admission into methadone treatment, intake physical for non-methadone recipients, methadone treatment plan review, medication management, medication dispensing, and urinalysis and detoxification services.

The fee schedule was last updated to be effective for services on or after 7/1/2019 and is available at <http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx>.

For SFY 2020, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the rates that were effective 1/1/2019.

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.

For family and client support services see Mental Health Rehabilitation Services.

Payment methodology for all types of targeted case management

Payment for Infant Learning Program Targeted Case management will be based on a monthly encounter rate. The payment rate is calculated prospectively and is based on the following:

Rate computation methodology

The prospective rate for payment of case management services is computed annually using the following formula. The data for this computation will be taken from the base year, that is the first full year before providers billed for Targeted Case Management services under this section, and will be inflated forward using an inflation index approved by the Department. For fiscal years, 2016, 2017, 2018, and 2020 the data for this computation taken from the base year will not be inflated forward.

<u>Compute the</u>	Annual case manager salary and fringe benefits
<u>Plus</u>	Other anticipated operating cost including travel, supplies, telephone, and occupancy cost
<u>Plus</u>	Direct supervisory cost
<u>Plus</u>	Average indirect administrative cost of provider organization
<u>Divided by</u>	Total statewide number of case managers
<u>Equals</u>	Total statewide annual cost per case manager
<u>Divided by</u>	12
<u>Equals</u>	Monthly statewide average cost per case manager
<u>Divided by</u>	Statewide average number of children served per month
<u>Equals</u>	Total statewide average monthly cost per child

The total cost per case manager is the sum of the case manager's reasonable salary, direct supervisory cost, indirect administrative costs of the provider organization, and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average statewide monthly cost per manager. Dividing the statewide monthly cost per case manager by the average monthly number of children served statewide results in the total monthly cost per child. This is the encounter rate to be used by the provider for billing whenever a Medicaid eligible client receives a TCM service during the month. Providers may only bill the encounter rate once per child per month and must keep documentation to verify this practice.

Payment Methodology for Under 21 Targeted Case Management

Rate determination: The monthly rate for case management services is based on the total average monthly cost per client served by the provider. The monthly rate is limited to the provider's direct service and administrative costs associated with case management service delivery. The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established prospectively. In the first year, the rate is based on estimates of cost and the number of clients to be served. For subsequent years, the rate is based on actual case management costs for previous years. A cost statement is completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. An encounter is a case management activity performed on the client's behalf. Each encounter will be documented to support the billing. Encounters include but are not limited to in-person, phone, mail, email, and other means.

Payment Methodology for Tribal Targeted Case Management

"Unit" is defined as a month. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process.

Payment for tribal targeted case management will be made using a monthly rate based on the total average monthly cost per case management client served by the provider during the fiscal year ending 12 months before the beginning of the prospective rate year. Direct and related indirect costs that are paid by other Federal programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first 3 years, the rate will be based on estimates of cost and the number of clients served. For subsequent years, the rate will be actual monthly case management costs per case management client served by the provider from the fiscal year ending 12 months before the beginning of the prospective rate year. A cost report and audited financial statements must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the prospective rate year beginning 12 months after the end of the fiscal year.

Long Term Services and Supports (LTSS) Targeted Case Management:

Reimbursement to providers of long-term services and supports (LTSS) targeted case management services provided on or after July 1, 2019, is a monthly fee for service at rates based on:

- Salaries
- Fringe Benefits
- Allowable Indirect Costs
- Average caseload size

Payment Methodology: The Department of Health and Social Services (the department) will authorize case management as a service within the participant support plan. Payment will be made through MMIS and each encounter will be documented to support the billing. The department established regulations for the operation of long term services and supports targeted case management services in a manner that protects and promotes the health, safety, and welfare of participants. The fee schedule will be rebased at least every four years. In the years in which the fee schedule is not rebased, the payment rate will be increased using the most recent quarterly publication available 60 days before July 1 of Global Insights Health Care Cost Review, CMS Home Healthy Agency Market Basket. For SFY20, July 1, 2019 through June 30, 2020, inflation will not be granted.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers. The fee schedule was last updated to be effective for services on or after July 1, 2019, and is available at http://www.dhss.alaska.gov/dsds/Documents/pca/Chart_LTSSTargetedCase%20Management_7-1-2019.pdf.

For SFY20, July 1, 2019 through June 30 2020, the payment rate will be set at 95% of the payment rate for SFY19.

Transportation Services

Emergency and non-emergency transportation services are paid at the lesser of the amount billed the general public or the state maximum allowable if such a maximum has been established. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20. State developed fee schedule rates are the same for both public and private providers. The agency's fee schedule rates and effective dates are published at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

The following types of emergency transportation services for recipients are payable at the lesser of the amount billed the public or the state maximum allowable, published at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>:

- Ground ambulance service, whether within the same community or outside of it;
- Air ambulance service.

For SFY20, July 1, 2019 through June 30, 2020, the payment rate will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20.

The following types of non-emergency transportation services for recipients and authorized escorts are payable at the amount billed the public or the state negotiated rate, when applicable:

- Commercial airline service;
- Ferry service;
- Ground transportation.

For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20. The State maintains files of negotiated rates.

With the exception of government-operated accommodations, meal and lodging costs for recipients and approved escorts are reimbursed at the lesser of the amount billed the public or the state maximum allowable per day, which is the government rate established for all publicly funded travel-related room and board. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20.

Costs for recipients and approved escorts utilizing government-operated accommodations are reimbursed at the federal per diem rate or the per diem rate established by the State of Alaska, whichever the provider chooses; or, if less, the amount billed to the public.

Prior authorization is required for all non-emergency transportation and all lodging and meal costs for both recipients and escorts.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Telemedicine Applications

Payment for services delivered via telemedicine is made according to the Medicaid payment methodology for the service and provider type. Reimbursement is made for a telemedicine application if the service is:

1. An initial visit;
2. A follow-up visit;
3. A consultation made to confirm a diagnosis;
4. A diagnosis, therapeutic referrals/orders, or interpretive service;
5. A psychiatric or substance abuse assessment; or
6. Psychotherapy or pharmacological management services on an individual recipient basis.

Separate reimbursement is not made for the use of technological equipment and systems associated with a telemedicine application to render the service.

Vision Care Services

Reimbursement is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU.

The state awards a competitive-bid contract for eyeglasses.

The fee schedule and effective date is available at

<http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>

Optometry Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both governmental and private providers. The agency's rates and its effective dates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

**Methods and Standards for
Establishing Payment Rates: Other Types of Care**

Tobacco Cessation

Pharmacies providing prescribed tobacco cessation medication therapy management through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or the tobacco cessation counseling fee of \$16.00.

Vaccine Reimbursement

For Medicaid eligible individuals through 18 years of age –

- 1) Administration of Preventive Vaccines is only reimbursed via an Administration fee to participating/enrolled Alaska VFC providers under the Vaccines for Children (VFC) program. Information regarding the VFC program is found on page 66(b) of Alaska's Medicaid State plan.

For Medicaid eligible individuals aged 19 and over –

- 1) Qualified, enrolled, licensed, Medicaid providers in Alaska practicing within their scope of practice will be reimbursed an administration fee as follows:
- 2)
 - a) Physicians will be reimbursed the lesser of billed charges or 100% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.
 - b) Nurse practitioners and physicians assistants will be reimbursed the lesser of billed charges or 85% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.
 - c) Pharmacists will be reimbursed the lesser of the estimated acquisition cost or billed charges plus an administration fee of \$17.46. Qualified pharmacists as authorized under "Other Licensed Practitioners" at 42 CFR 440.60 are not eligible to receive a dispensing fee for vaccines when an administration fee is paid.

State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at <http://www.medicaidalaska.com/providers/Billing.shtml>. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11.

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Supersedes: 11-007

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL HEALTH FACILITIES
(Continued)

Other Services

Dental Services

Effective January 1, 2008 Tribal Dental services are reimbursed at the most current outpatient per visit rate published in the federal register by the Indian Health Service. For the calendar 2007 transition year Tribal Dental services will be reimbursed at the 2007 outpatient per visit rate adjusted by the Indian Health Service with the previously excluded dental costs and workload statistics.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL HEALTH FACILITIES
(Continued)

Other Services-Cont'd

Behavioral Health Services

Payment for Behavioral Health Services is made at the most current outpatient per visit rate published in the federal register by the Indian Health Service.

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Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

The Medicaid agency will adjust payments for provider health care-acquired conditions and other provider preventable conditions as follows: after post payment review of the medical record by a QIO, the Medicaid agency will reduce payment by recouping funds that were paid for dates of service that were a direct result of a provider preventable condition.

In compliance with 42 CFR 447.26(c), the Medicaid Agency provides:

- 1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
- 2) That reductions in provider payment may be limited to the extent that the following apply:
 - i. The identified provider preventable conditions would otherwise result in an increase in payment.
 - ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.
- 3) Assurance that non-payment for provider preventable conditions does not prevent access to services for Medicaid beneficiaries

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

 Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 B

 √ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

 Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

Supplemental Emergency Medical Transportation Reimbursement

The Supplemental Emergency Medical Transportation (SEMT) reimbursement is a voluntary program making supplemental payments to eligible SEMT providers furnishing qualifying emergency medical transportation services to Medicaid-eligible beneficiaries. The SEMT program operates using the certified public expenditure (CPE) payment method.

Supplemental reimbursement via the SEMT is permissible only for the allowable and compensable costs of providing emergency medical transportation services to Medicaid-eligible beneficiaries in a fee-for-service (FFS) environment. Using the cost report, eligible SEMT providers must certify the total expenditures incurred in the provision of qualifying SEMT services to the Department of Health and Social Services (the Department) for use in the determination of the amount of supplemental reimbursement to individual providers through the program.

The SEMT payment reduces the discrepancy between a provider's total allowable costs for providing SEMT services, as reported on the cost report, and all other sources of reimbursement.

The Department makes supplemental payments only up to the amount of the federal share of uncompensated costs that exceed reimbursement from all other sources. Total reimbursement from the Department, including the federal supplemental payment, may not exceed one hundred percent of actual costs. The Department does not consider SEMT payments an increase to current FFS reimbursement rates.

Implementation of the SEMT program may not result in additional expenditures from the state general fund.

As a condition of participation under this program, an eligible provider must agree to reimburse the state Medicaid agency via an administration fee for any costs associated with implementing the SEMT program.

This supplemental reimbursement applies only to eligible SEMT services, rendered to Alaska Medicaid-eligible FFS beneficiaries, by eligible SEMT providers on or after July 1, 2019.

A. Definitions

1. "Department" means the Alaska Department of Health and Social Services
2. "Allowable costs" means an expenditure that meets the test of the appropriate Executive Office of the President of the United States' Office of Management and Budget Circular (OMB).
3. "Cognizant agency" is the federal agency with the largest dollar value of direct federal awards with a governmental unit or component.
4. "Cost Allocation Plan (CAP)" is a document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The document also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received. For SEMT purposes, providers must use their local governments' approved CAP.
5. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:
 - a. Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; or

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- b. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
6. “Direct federal award” means an award paid directly from the federal government. SEMT is not a direct award as it is paid through the Department.
7. “Eligible SEMT provider” means a provider meeting all of the eligibility requirements described [in Section B] below.
8. “Federal financial participation (FFP)” means the portion of medical assistance expenditures for emergency medical services paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the approved state plan for medical assistance. Clients under Title XIX, Title XXI, and the Affordable Care Act (ACA) are eligible for FFP.
9. “SEMT Services” means the act of an enrolled SEMT provider transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, and basic life support services provided to an individual by enrolled SEMT providers before or during the act of transportation.
10. “Indirect costs” means costs that cannot be readily assigned for a common or joint purpose benefitting more than one cost objective,
11. “Publically owned or operated” means a unit of government, which is a state, city, county, special purpose district, or a governmental unit in the state with taxing authority, direct access to tax revenues, or an Indian tribe as defined in Section 4 of the Indian Self Determination and Education Assistance Act.
12. “Service period” means the provider’s designated fiscal year.

B. SEMT Provider Eligibility Requirements

To be eligible for supplemental payments, SEMT providers must meet all of the following requirements:

1. Be enrolled as a Medicaid provider for the period claimed on their annual cost report
2. Provide ground, air, or water emergency medical transportation services to Medicaid enrollees.
3. Be organizations owned or operated by the state, city, county, fire protection district, community services district, health care district, federally recognized Indian tribe, or any unit of government as defined in 42 C.F.R. Sec. 433.50.

C. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.
2. Medicaid base payments to the eligible SEMT providers for SEMT services are derived from the applicable emergency transportation FFS fee schedule(s) established for Medicaid program

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reimbursement by procedure code. The primary source of paid claims data and other Medicaid reimbursements is the Alaska Medicaid Management Information System (MMIS). The number of paid Medicaid FFS SEMT transportation episodes is derived from, and supported by, MMIS reports for services during the applicable service period.

3. The total uncompensated care costs for each eligible SEMT provider available for reimbursement under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible SEMT provider providing SEMT services to Alaska FFS Medicaid beneficiaries, net of the amounts received and payable from the Alaska Medicaid program and all other sources of reimbursement for such services provided to Alaska Medicaid beneficiaries.

A single cost report will be utilized to separately calculate the allowable costs and the average cost per transport for each type of transportation provided for those providers offering more than one type (ground, air, water) of emergency transportation service. If the eligible SEMT providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under SEMT. The total reimbursement from Medicaid, including the federal supplemental payment, must not exceed one hundred percent of the actual cost of providing emergency medical transportation services to eligible Alaska FFS Medicaid beneficiaries.

D. Cost Determination Protocols

1. An eligible SEMT provider's specific allowable cost per-medical transport rate for ground, air, and water will be calculated based on the provider's audited financial data reported on the cost report. The average emergency medical transport for each ground, air, and water will be the sum of actual allowable direct and indirect costs of providing each applicable medical transportation service divided by the actual number of medical transports for ground, air, or water provided for the applicable service period.
2. Direct costs for providing medical transportation services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must comply with the Medicaid non-institutional reimbursement policy and be directly attributable to the provision of medical transport services.
3. Indirect costs are determined in accordance with one of the following options.
 - a. Eligible SEMT providers receiving more than \$35 million in direct federal awards must have either a Cost Allocation Plan (CAP) or a cognizant agency-approved indirect rate agreement in place with its cognizant federal agency to identify indirect cost. If the eligible SEMT provider does not have a CAP or an indirect rate agreement in place with its cognizant federal agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.

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- b. Eligible SEMT providers receiving less than \$35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, eligible SEMT providers may use methods originating from a CAP to identify its indirect cost. If the eligible SEMT provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.
- c. Eligible SEMT providers who receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
 - i. A CAP with its local government
 - ii. An indirect rate negotiated with its local government
 - iii. Direct identification through the use of a cost report
- d. If the eligible SEMT provider never established any of the above methodologies, it may do so, or it may elect to use the 10% *de minimis* rate to identify its indirect cost.

E. Interim Supplemental Payment

1. Each eligible SEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section D) and must submit the completed annual as-filed cost report, to the Department within five (5) months after the close of the provider-designated fiscal year.
2. The Department will make annual interim supplemental payments to eligible SEMT providers. The interim supplemental payments for each provider are based on the provider's completed annual cost report in the format prescribed by the Department for the applicable cost-reporting year.
3. To determine the annual interim supplemental payments, the Department must use the most recently filed cost reports for all qualifying providers. The Department will then determine the cost per transport for each service, which will vary between the qualifying providers. The interim supplemental payments will only be for services that are determined to be emergency medical transports. The interim payments are the federal portion of the difference between the providers' cost per transport and Medicaid fee-for-service payments from the MMIS. The Title XIX Federal Medical Assistance Percentage (FMAP) will be used to calculate the federal portion for the interim payments. The number of emergency medical transports will be for services paid through the MMIS for the time period that matches the dates of service on the most recently filed cost reports.

F. Cost Settlement Process

1. The Medicaid payments and the number of transport data reported in the as-filed cost report will be reconciled to the Alaska MMIS reports generated for the cost-reporting period within **three (3)** years of receipt of the as-filed cost report. The Department will adjust the as-filed cost report based on the results of reconciliation with the most recently retrieved MMIS report.

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2. The Department will compute the net SEMT allowable costs using audited per-medical transport cost, and the number of emergency medical fee-for-service SEMT transports data from the updated MMIS reports. The MMIS reports will categorize Medicaid payments and units of service into groups for each service (ground, air, water) based on 1) emergency medical transports, and 2) nonemergency medical transports, and only settle to cost for emergency medical transports.

The MMIS reports will further categorize Medicaid payment and units of service into groups based on the FMAPs such as 1) Title XIX, 2) Title XXI, 3) the Affordable Care Act Medicaid Expansion, and 4) Indian Health Services – including claims by non-IHS providers that have been tribally refinanced in accordance with State Health Official letter #16-002 to determine the appropriate federal portion of the difference between the provider’s cost per transport and the Medicaid FFS payments from the MMIS.

Actual net allowable costs for emergency medical transports will be compared to the total base and interim supplemental payment and settlement payments made, and any other source of reimbursement received by the provider for the period. If at the end of the final reconciliation, it is determined that the SEMT provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is determined, then the SEMT provider will receive a supplemental payment for underpayment

G. Eligible SEMT Provider Reporting Requirements – a SEMT provider must:

1. Report and certify total computable allowable costs annually on a Department- approved cost report. Eligible providers will submit cost reports no later than five (5) months after the close of the provider’s designated fiscal year unless a provider has made a written request for an extension and the department grants the request. A request for an extension must be submitted no later than 30 days before the “no later than” submission date five-months after the close of the provider’s designated fiscal year. Failure to submit the required information on time will result in the provider’s exclusion from the SEMT program for the provider’s designated fiscal year.
2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination as specified by the Department.
3. Keep, maintain, and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS for a period of seven years.
4. Comply with the allowable cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, 2 C.F.R. Part 200, and Medicaid non-institutional reimbursement policy.

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H. Department Responsibilities

1. The Department will submit to CMS claims based on total computable certified expenditures for SEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.
2. The Department will submit, on an annual basis, any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.
3. The Department will complete the audit and reconciliation process of the interim payments for the service period within three years of the postmark date of the cost report and may conduct on-site audits as necessary.